Best Practice Initiative
from the Assistant Secretary for Health
U.S. Department of Health and Human Services

Air Force Suicide Prevention Program
A Population-based, Community Approach

The United States Air Force Medical Service (2002)

This population-based prevention program enlisted involvement over several years by a broad coalition of community agencies, both inside and outside the health care sector, to significantly reduce suicide among Air Force personnel.

Background

From 1990-1995, suicide rates were rising at a statistically significant pace among Air Force personnel overall, and among both African-American and Caucasian enlisted male subgroups. By the end of the period, the overall rate was reaching all time record high levels for the Air Force, though it remained comparatively lower than that of the U.S. population overall when corrected for age, gender, and race. Early in 1996, the Air Force Chief of Staff commissioned the Surgeon General to lead a systematic study of the issue and recommend a prevention strategy. The team included representatives of 15 Air Force functional areas and experts from Centers for Disease Control and Prevention and academia. Employing a data-driven prevention model to guide its search of extant community data, it identified nine factors that were frequently associated with victims of suicide and three factors it concluded were protective. Stigma, cultural norms, and beliefs that combined to discourage help-seeking behavior were identified as major hurdles to successful suicide prevention.

The Intervention

With the strong and visible support of the Air Force Chief of Staff, the cross-functional team began the work of implementing eleven recommendations aimed at mitigating risk factors and strengthening the protective factors for suicide. The risk factors identified included problems with the law, finances, intimate relationships, mental health, job performance, and alcohol and other substance abuse. These were often further complicated by social isolation and poor coping skills. The team identified three key protective factors: a sense of social support, effective coping skills, and policies and norms that encourage effective help-seeking behaviors.

Changing Social Norms: Promoting Social Support and Help-Seeking Behavior

Through a series of hard-hitting messages to the force, the Air Force Chief of Staff repeatedly and unequivocally communicated the urgent need for Air Force leaders, supervisors, and frontline workers to support each other during the inevitable times of heightened life stress.

Whether encountering the break-up of an intimate relationship, financial difficulties, legal problems, or frequently some combination of these, Air Force personnel were encouraged to personally offer assistance where possible and to promote use of community resources when necessary. He specifically encouraged airmen to seek help from mental health clinics and pointed out that when airmen seek help early it is likely to enhance their career rather than hinder it. Further, he instructed commanders and supervisors to support and protect those who responsibly seek this kind of help. Finally, he removed policies that acted as barriers to mental health care for those being charged with violations of military law.

Educating Community Members

The team established policy requiring all Air Force personnel to receive annual instruction on suicide risk awareness and prevention. A curriculum outline was provided at the inception of the program, calling on instructors at each Air Force installation to innovatively develop their presentations. In 2000, the best of the "home-grown" programs were carefully reviewed with the help of nationally recognized experts to produce a best practice tool kit for community education. This resource is available at https://www.afms.mil/phsd/PHSO/ToolKits/.

Career officers and enlisted members typically complete three professional development courses over the span of their careers. Each of these academic courses were infused with appropriately targeted curricula on suicide prevention to augment their annual training. Students are tested on the curricula.

Improving Surveillance

A Web-based epidemiological database was established to capture demographic, risk factor, and protective factor information pertaining to individuals who attempted or completed suicide. Highly secure to protect privacy, this tool allows leaders to quickly detect suicide clusters or changes in patterns in suicidal behavior that could inform needed change in policies and practices across the Air Force community.

Additionally, commanders were given a unit-based survey tool to assess aggregate risk among their subordinates. Anonymously administered, the Behavioral Health Survey assesses risk along several validated scales and tells the commander how his or her unit compares with the Air Force as whole. A cross-functional team on each base suggests interventions tailored to specifically address areas of elevated risk.

Critical Incident Stress Management

Critical incident stress management teams were established to serve personnel at every installation, with deployable teams available to provide additional resources to installations hard hit by potentially traumatizing events. These teams respond to events such as combat deployments, serious aircraft accidents, and natural disasters as well as suicides within the military unit.

Integrated Delivery System for Human Services

The Chief of Staff required the principle agencies at each geographical location to work together to assess the needs of the population they serve, develop a consolidated plan targeting their collective resources to a prioritized list of those needs, collaboratively market the resources to the community, and evaluate the effectiveness of their plan. Several of the agencies' headquarters contributed funding for training in support of this new initiative. Leaders from the Chapel programs, mental health services, Family Support Centers (providers of financial counseling, career counseling, support services for families of deployed service members, and others), Child and Youth Programs, Family Advocacy (domestic violence prevention), and Health and Wellness Centers are involved on each installation.

Each of these initiatives are described in detail in Air Force Pamphlet 44-160, *The Air Force Suicide Prevention Program*, and is available on the World Wide Web at: http://www.e-publishing.af.mil/pubfiles/af/44/afpam44-160/afpam44-160.pdf.

Results

When the project began in 1995, suicide was the second leading cause of death among the 350,000 Air Force members, occurring at an annual rate of 15.8/100,000. Since then, the suicide rate declined statistically significantly over three consecutive years, and for the first six months in 1999 the annualized rate fell below 3.5/100,000. This is more than fifty percent less than the lowest rate on record prior to 1995 and an 80 percent drop from the peak rates in the mid-90s. The suicide rates increased in '00 and early '01, but have declined again since April '01 and have remained much lower than rates prior to 1995. Statistically significant declines in violent crime, family violence and deaths due to unintentional injuries have also been measured concurrently with the intervention. Air Force leaders have emphasized community-wide involvement in every aspect of the project. The providers of community-based human services have made significant progress in coordinating their resources for the purpose of building stronger individuals and more resilient communities.

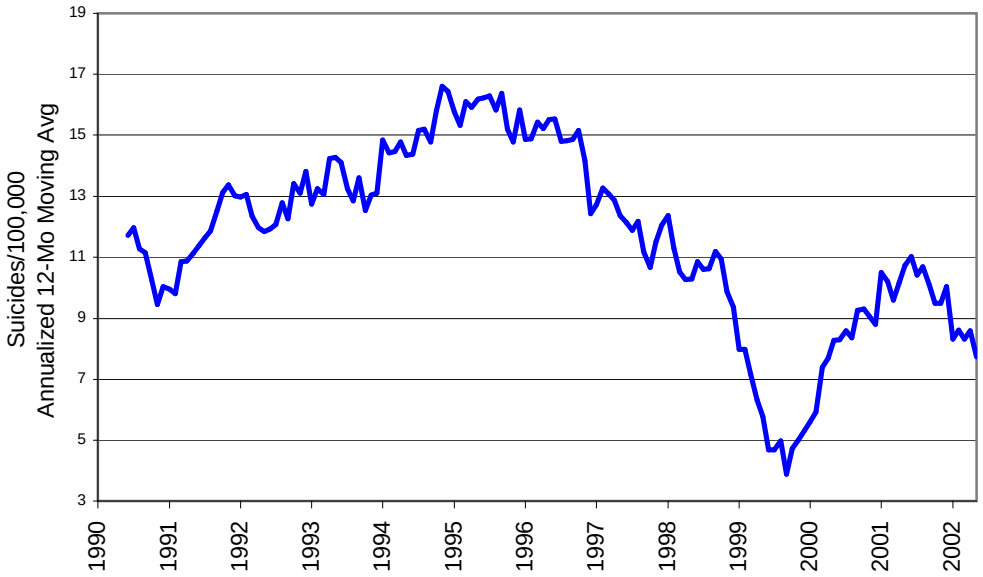
The suicide rates in the United States also declined in the second half of the decade of the 1990s. This decline, however is extremely small compared to that measured in the Air Force. Explanations commonly advanced for the national declines have included a robust economy with historically low unemployment, declines in hard drug use, and increased utilization of the most commonly prescribed anti-depressant medications. Although the first two would not be expected to have been a factor for the special population in the Air Force, it would be useful to study the influence the third may have had in the context of attempting to de-stigmatize seeking help for mental health problems. An independent, retrospective evaluation of the Air Force suicide prevention program was recently completed and is under review at the time of this writing. A five-year study to prospectively evaluate each of the program's components is now underway.

Is the Air Force Program Transferable to Civilian Communities?

The Air Force community shares many characteristics with other American communities, and yet in some ways is quite distinct. For instance, the Air Force, like other communities, has identifiable leaders that can influence community norms and priorities. Human services, including health care, are delivered through a labyrinth of community agencies and organizations

that are not well connected. The community has elements of a common identity, but at the same time is a collection of widely diverse individuals. There is an established network of gatekeepers—people who open gates to helping resources for individuals in need. The Air Force is distinct in that its leadership authority is especially concentrated and hierarchical, all members are employed by the same employer, housing and health care—including mental health care—is universally available, the population is pre-screened for serious brain disorders, and the gatekeeper network is unusually well organized. These distinctions have likely sped the implementation of the program and increased its penetration. None-the-less, the over-arching principles, such as leveraging community leaders to change cultural norms, engaging and training established networks of gatekeepers, improving coordination of broadly diverse human services, and providing educational programs to community members should be transportable to any civilian community with some minimal level of organization and cohesion.

Suicide Rate -- US Air Force Members 1990-2002



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